



Integration of Behavioral Health and Primary Care

Change Agent Conference

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Why do it?

What is *it*?

What are the *options*?

High Co-occurrence of Behavioral Health and Physical Health Conditions

- 50% of people with BH problems are seen in primary care
- 68% of people with BH problems in primary care do not get treatment or are under treated
- 29% of people with chronic health conditions have MH issues, receive little treatment and have poor outcomes
- 68% of adults who have a mental illness have at least one health condition
- People with BH disorders have 25 year shorter life expectancy
- 2/3 of primary care physicians reported not being able to access outpatient BH for their patients

Where are Alaskans Getting BH Services?

Fy11 Adults

- Inpatient Hospitals and Residential Psychiatric Treatment Centers = 6%
 - API
 - Other Acute Psych Hospitals
 - RPTC's
- Hospital Outpatient = 19%
 - Private Hospital
 - Tribal Hospital
- Community BH = 54%
 - Mental Health
 - Substance Abuse
- Other Community/Clinic = 20%
 - Physician Clinics
 - Psychologist
 - Indian Health Service
 - Rural Health
- Other = 39%
 - Physicians, Nurse Practitioners and School-Based Services

Where are Alaskans Getting BH Services?

Fy11 Youth

- Inpatient Hospitals and Residential Psychiatric Treatment Centers = 11%
 - API
 - Other Acute Psych Hospitals
 - RPTC's
- Hospital Outpatient = 17%
 - Private Hospital
 - Tribal Hospital
- Community BH = 46%
 - Mental Health
 - Substance Abuse
- Other Community/Clinic = 33%
 - Physician Clinics
 - Psychologist
 - Indian Health Service
 - Rural Health
- Other = 50%
 - Physicians, Nurse Practitioners and School-Based Services

High Cost of Health Care for People with BH Issues

- People with severe mental illness served by public mental health systems have rates of co-occurring chronic medical illness 2 – 3 times higher than general population
- Treatment of these chronic medical conditions comes from costly ER visits and inpatient stays

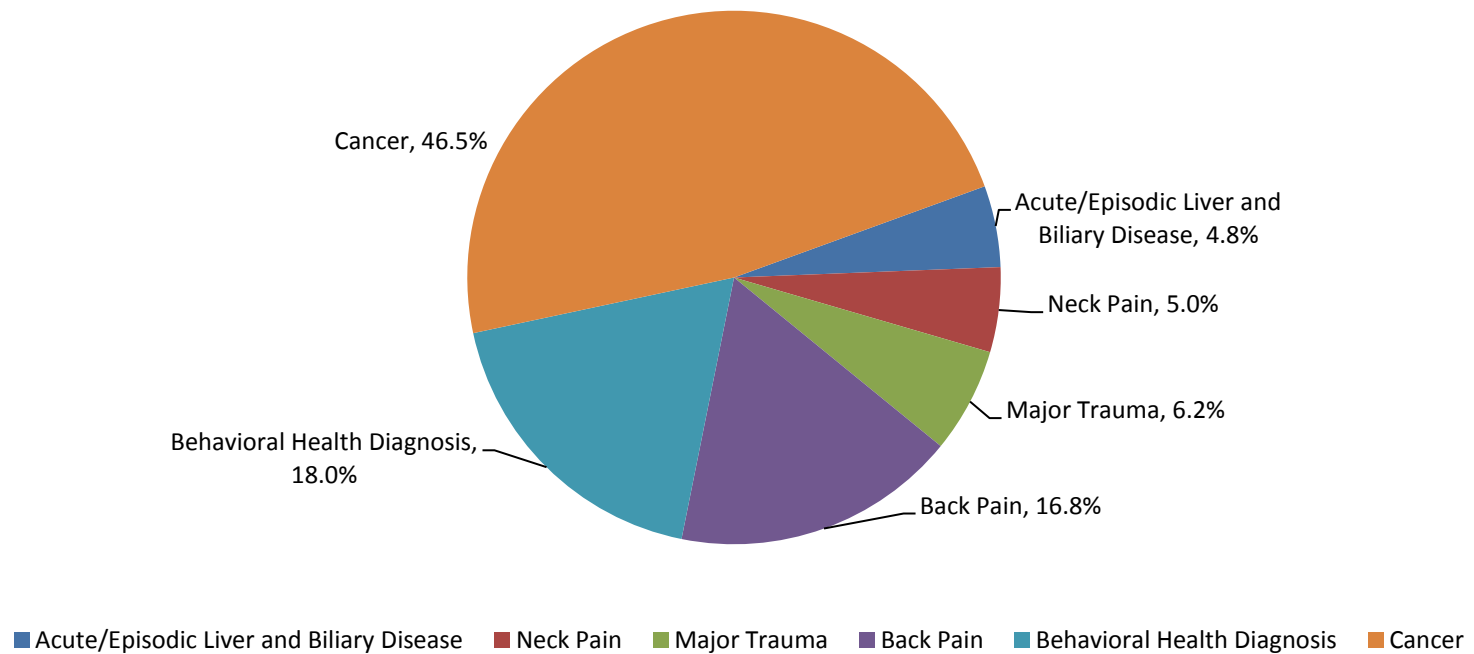
Example

- Alaska: SFY 2011- 2012
 - Focused on 8,763 Medicaid clients served by DBH grantees in FY 2012
 - Accounted for \$83,753,273 in BH Medicaid claims
 - Accounted for \$224,102,758 in all Medicaid claims
 - 99% had at least one chronic condition
 - With an average cost of \$25,574 in Medicaid claims.
 - This represents 7% of Medicaid clients and 18% of total payments.
 - 1,515 clients of DBH grantees are in the top 5% most expensive Medicaid clients.

Example

- 2003 in Missouri
 - 19,000 Medicaid recipients had dx of schizophrenia
 - Highest 2,000 had a combined cost of \$100 million in Medicaid claims
 - 80% of the costs were for urgent care, emergency room and inpatient episodes
 - The \$100M spent on these 2,000 represented 2.4% of all Missouri Medicaid expenditures for the states 1 million eligible recipients

Frequency of Primary Diagnosis of High Cost Member (>\$25,000 PMPY)



Information from AlaskaCare Employee Health Plan presentation to the AK Health Care Commission October 2012. Info based on claims incurred from July 2010 to June 2012.

Three Major Issues

- Primary care is the de facto behavioral health provider
- Care is ineffective
- People with co-occurring problems cost more

What Is It?

Stepped Care

Inpatient treatment

BH specialty long term care

BH specialty short term care

Psychiatric consultation

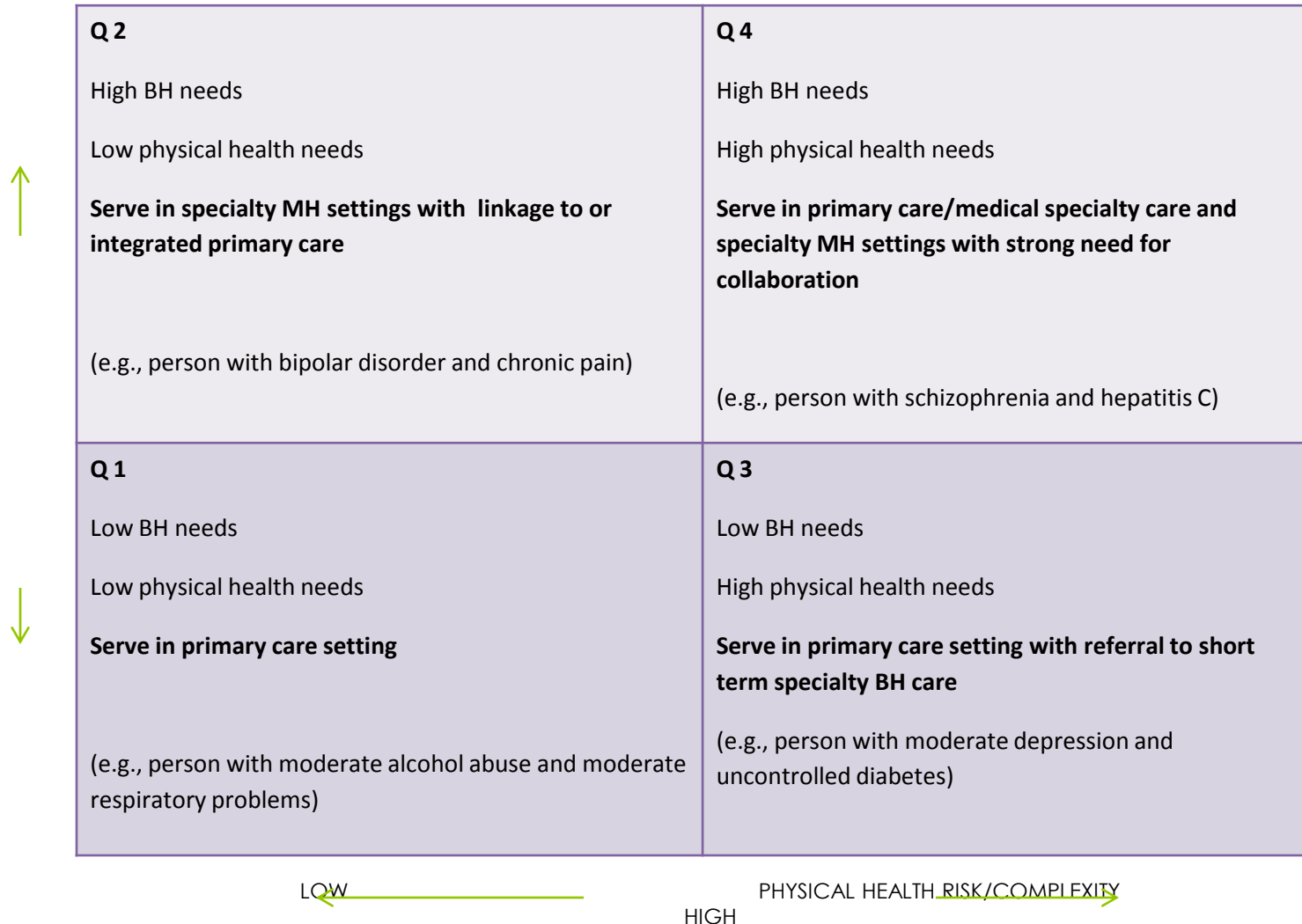
Primary care + behavioral health care

Primary care

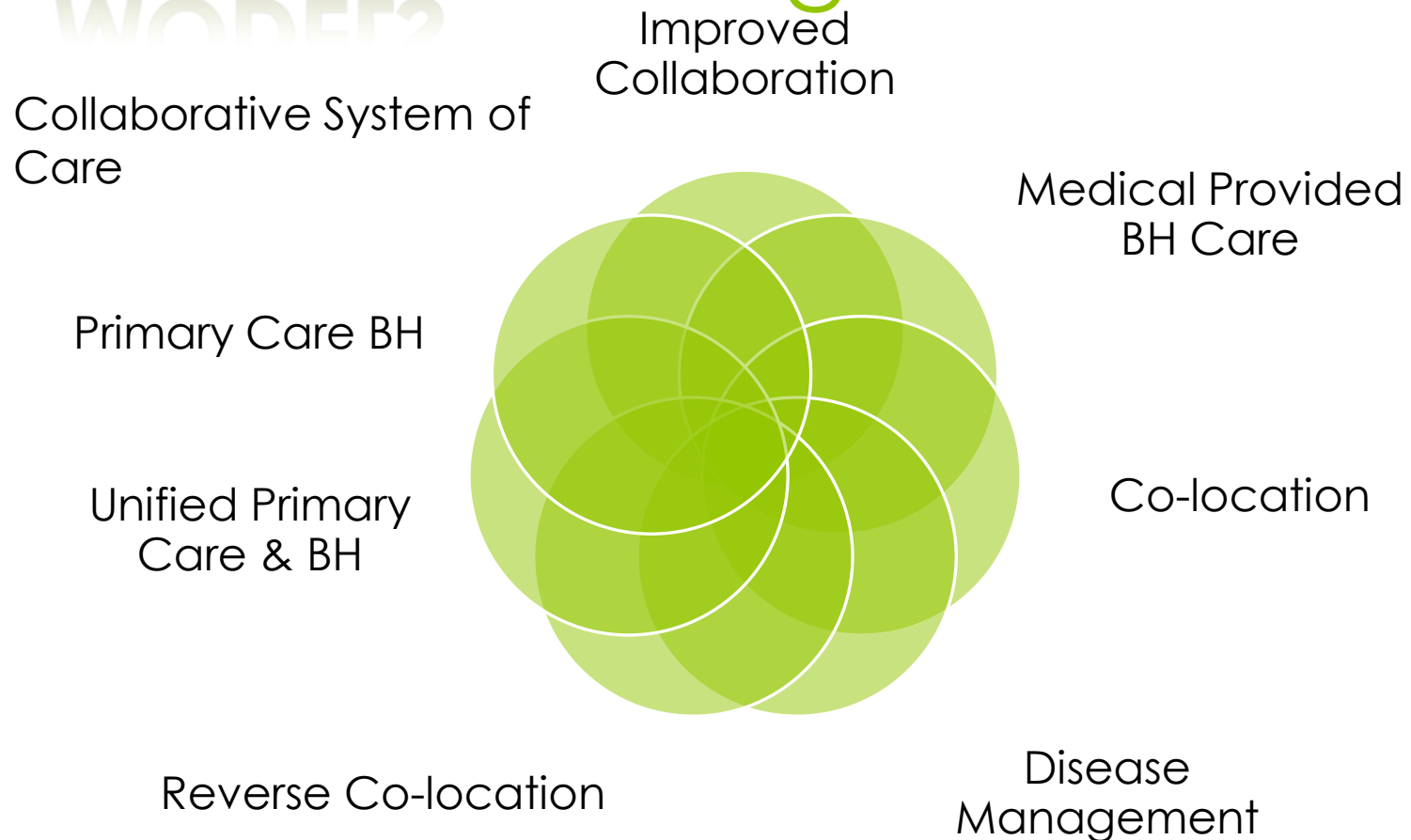
Self care

Matching the Degree of Integration and Coordination with the Need and Resources

Four Quadrants of Clinical Integration Based on Patient Needs



MODELS of Integration



Minimal Collaboration	Basic Collaboration at a Distance	Basic Collaboration On-Site	Close Collaboration in a Partly Integrated System	Close Collaboration in a Fully Integrated System
BH and PC work in separate facilities, have separate systems, communicate sporadically	BH and PC providers have separate systems at separate sites, communicate periodically by letter or phone on shared patients	BH and PC have separate systems, share same facility, increased communication; providers remain in their own systems	BH and PC share same facility, share some systems like appts or EHR, collaborate as a team on shared patients	BH and PC are part of the same team; BH treatment is part of primary care

Identify the Problem

- Screening
 - PH-Q 9 and PH-Q 2
 - Suicide risk assessment
 - SBIRT
 - AST (Note: includes PH-Q(and PH-Q2)

Matching the BH Skills to the Needs

- ◉ **Motivational interviewing**
- ◉ **Stress reduction**
- ◉ **Behavioral activation**
- ◉ **Solution-focused brief treatment**

Treat to Target

What Can YOU Do NOW?

Ask and Tell

- Use BH Screening tools
 - Alaska Screening Tool (billable)
 - Client Status Review (billable)
 - SBIRT (billable)
- Find out About Physical Health
 - Provider
 - Health History (Personal and Family)
 - When was last H&P?

- Use peer support services
- Develop relationship with medical providers
- Provide education on BH issues to medical providers
- Get education on chronic health conditions
- Include health care goals in treatment plans

- Assist in scheduling and keeping medical care appointments
- Build processes for referral and follow-up with primary care
- Provide information or referral regarding nutrition and exercise programs
- Offer smoking cessation (billable)

Whole Health
It's what we all want.
It's what we all deserve.